



PALM DESERT DENTIST

Cosmetic, Resorative & Implant Dentistry

Craig Conrow, DDS • Robert McLachlan, Jr., DDS

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Social Security # _____ Birth Date _____ Gender M / F
Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____
Address _____
Street City State Zip Code
Out of State Address _____
Street City State Zip Code
Email Address _____
Occupation _____ Employer _____ Best time to call _____
Marital Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Spouse's or Parent's Name _____ Relationship _____
In case of Emergency Contact _____ Phone _____

NONE

INSURANCE INFORMATION

Primary:
Name of subscriber _____ Birth date ____/____/____ Social Security # _____
Relationship to Patient: _____ Home Ph. (____) _____ Work Ph. (____) _____
Name of Employer: _____
Address City State ZIP
Insurance Company: _____ Group # _____ Union or Local # _____
Ins. Company Address: _____
Address City State ZIP

Secondary:
Name of subscriber _____ Birth date ____/____/____ Social Security # _____
Relationship to Patient: _____ Home Ph. (____) _____ Work Ph. (____) _____
Name of Employer: _____
Address City State ZIP
Insurance Company: _____ Group # _____ Union or Local # _____
Ins. Company Address: _____
Address City State ZIP

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____
Friend _____ Internet _____ Television _____ Phone Book _____ Other _____

Do you live here? ☐ Full time ☐ Seasonal from _____ to _____

In our efforts to be efficient, conscious of the world we live in, and supportive of protecting our planet we communicate through email and text messages to our patients regarding appointments. Which do you prefer we use to contact you?
☐ Email ☐ Text message?

CONFIDENTIAL HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cancer Of _____ | <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke: Date _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Smoke/Tobacco Use |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Metals Allergy |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> HIV | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Diabetes (Type) _____ | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Artificial Joints _____ | <input type="checkbox"/> Jaundice / Cirrhosis | <input type="checkbox"/> Head Injuries | |
| (Date) _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | Women: |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Venereal Disease | Due date: _____ |

Do you have or have had any disease, condition, or problems not listed? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

List Current Medications _____

DENTAL HISTORY:

- Have you ever taken Biphosphonate (for Osteoporosis or Bone Cancer)? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Date of Last Dental Visit: _____ Reason for this visit: _____

Last Cleaning _____ Last Full Mouth X-Ray _____ Previous Dentist Name _____

ARE ANY OF YOUR TEETH SENSITIVE TO:

Hot or cold	Yes	No
Sweets	Yes	No
Biting Or Chewing	Yes	No

DO YOU:

Have gums that bleed or hurt?	Yes	No
Clench Or Grind Your Teeth?	Yes	No
Have any loose or missing teeth?	Yes	No
Have any broken teeth or tooth restorations?	Yes	No
Have tired jaws when you awaken?	Yes	No
Have difficulty in opening or closing your mouth wide or yawning?	Yes	No
Have pain (Ear, Jaw Joint, Side of Face)?	Yes	No
Do you feel or hear a clicking, popping or cracking noise from either jaw joint?	Yes	No
Have your jaw ever lock open or closed?	Yes	No
Have any change in how you bite?	Yes	No
Have mouth odors or bad taste?	Yes	No

HAVE YOU EVER HAD:

Orthodontic Treatment	Yes	No
Periodontal Root Planning/Scaling	Yes	No
Periodontal Surgery	Yes	No
Your Teeth Ground or The Bite Adjusted	Yes	No
A Serious Injury To The Mouth	Yes	No
Please describe _____		
Parents that had gum disease or tooth loss?	Yes	No
Nervousness about being in a dental office or having dental treatment?	Yes	No
An upsetting dental experience?	Yes	No
Please describe _____		

Would you prefer Nitrous Oxide or Oral Sedation when you have dental treatment?	Yes	No
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Are you satisfied with your teeth's appearance? Yes No

Would you like to improve the appearance of your teeth? Yes No

Is there anything else about having dental treatment you would like us to know? Yes No

Please describe _____

RESPONSIBLE PARTY

CONSENT FOR SERVICES: To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Conrow at the next appointment without fail.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All dental and surgical procedures are to be paid in full at the time of service. All sedation (anxiolysis) appointments require a 1 week cancellation notice. You will need to make a pre-treatment appointment at least 1 week prior to your sedated treatment appointment to receive your prescriptions, pre-op and post-op instructions, sign consents, and make your payment for treatment. This appointment is mandatory. It is not ethical for us to have you sign consents or take money from you on the day of your sedated treatment appointment because when you arrive to our office you will already have sedation medication in your body. This appointment should take 30 minutes. There is no charge for this visit.

Insured patients: You are financially responsible for any and all charges at Dr. Conrow's office. No matter what your insurance pays.

This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment in full. Any insurance benefits quoted are estimated; your actual indemnity may be less. If we are a contracted provider with your insurance we will accept your copayment at time of service. You are responsible for all amounts not covered by your insurance. If we are NOT contracted with your insurance company, you will pay for treatment in full and your insurance will reimburse you directly. For all patients with insurance, we will submit claims and all necessary documentation as required by your insurance company as a courtesy to you, but all payment responsibility lies with the patient. Understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. Any balance remaining on an account for over 30 days will be charged a finance charge of 18%. We offer a 5% prepayment courtesy if you pay with cash or check for treatment plans that are over \$5000.00 when you pay for the complete treatment plan at your pre-treatment appointment.

By signing below I acknowledge that I am here for treatment of my own free will and request my choice of treatment be done to correct the dental conditions that I have presented to Dr. Conrow/ Dr. Crowley. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and treatments.

I have read the above conditions of treatment and payment and agree to their content.

Should the need arise, I ☐ Agree ☐ Do Not Agree to give my permission to discuss any or all of my treatment with family members such as (please circle as many that apply):

Spouse Parent(s) Significant Other Guardian Grandparents Aunt / Uncle Children Care Giver Sister / Brother
Other: _____

WE RESERVE THE RIGHT TO CHARGE FOR CONFIRMED APPOINTMENTS THAT ARE BROKEN WITHIN 24 HOURS

Signature of patient, parent or guardian _____ Date _____

FOR OFFICE USE ONLY:

Initial Blood Pressure Record: _____ Pulse: _____ Taken by _____

Note Changes Below:	Patient Signature:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____